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Philosophical health: Unveiling the patient's personal philosophy with a person-centred method of dialogue

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Abstract

Grounded in ideas about sense-making and whole-person care with a long intellectual heritage, the movement for Philosophical Health—with its specific conceptions of philosophical care and counselling—is a relatively recent addition to the ongoing debate about understanding better the perspectives of patients to improve health practice. This article locates the development of this movement within the context of broader discussions of person-centred care (PCC), arguing that the approach advocated by defenders of philosophical health can provide a straightforward method for implementing PCC in actual cases. This claim is explained and defended with reference to the SMILE_PH method created by Luis de Miranda (*Sense-Making Interviews Looking at Elements of Philosophical Health*), an approach recently trialled convincingly with people living with traumatic spinal cord injury.

KEYWORDS
applied philosophy, interviews, person-centred care, phenomenology, philosophical health, sense-making

1 | INTRODUCTION

As has been argued extensively in this journal and elsewhere, the debate about person-centred care—and associated ideas including shared decision-making, values-based practice, patient empowerment and patient expertise—is an essential component of any serious discussion regarding the future of healthcare provision and practice.[1–9] We believe that the recent 'philosophical health' perspective[10–14] has a significant contribution to make to the development of the ongoing dialogue about who a person is in care situations and how we can practically integrate an understanding of the personhood of patients into the care process.

Just as person-centred care (PCC) represents a movement beyond previously dominant reductionist, mechanistic conceptions of physical and psychological health,[3,15–19] philosophical health is envisaged as a complement to physical and psychological health as they are currently understood in practice. Without abandoning the critical insights derived from reductionist, biomedical or quantitative accounts of persons and organisms, we need to revive ideas—regarding purpose, coherence, meaning and how people *make sense* of their lives—that are indispensable components of our understanding of a person's autonomy and well-being, but have been sidelined in the modern era.[3,9,11–13,20,21] Philosophical counselling attempts to make transparent and thus enable us to evaluate the relationship between our ideals, ideas and actions. It helps unveil the beliefs, worldviews and concepts integral to our personal and social existence.

In what follows, we will argue that we must engage in philosophical dialogue to know the person behind the patient. This can be done using a method called SMILE_PH—an acronym for

Sense-Making Interviews Looking at Elements of Philosophical Health. This approach was recently designed by Luis de Miranda and trialled with people living with traumatic spinal cord injury, in a pilot study conducted in collaboration with the Linköping University Hospital.[22] As we have argued elsewhere,[13,23] you do not need to be an academic philosopher to have 'a philosophy' or worldview. The SMILE_PH dialogue, within a framework that we call the patient's personal philosophy (PPP), provides the PCC approach with a scalable and expandable tool which nonphilosophers could use with minimal training. The method enables practitioners to co-create a phenomenological narrative with the patient about (1) their bodily sense, (2) their sense of self, (3) their sense of belonging, (4) their sense of the possible, (5) their sense of purpose and (6) their philosophical sense.

2 | FROM PCC TO PHILOSOPHICAL HEALTH

PCC has been described as an emergent model of modern clinical practice with the potential to revive the ancient conception of medicine as care for 'the whole person'.[4] The language of 'person-centredness' has recently been incorporated into numerous widely read, influential policy documents,[6,7] including the 2019 NHS long-term plan.[24] This language is now a core component of various debates about the future of health service provision and practice.[1,2] However, there is still a gap between discourse and practice because, despite much discussion and input on the principles of PCC, no straightforward method of dialogue has yet been systematically implemented to assess the PPP.

Without such a method, we lack a proper understanding of the patient's purpose, goals and values in the context of their particular life and the meaning and significance they ascribe to specific activities, experiences, relationships, processes and capacities.[3,25] One of the best-known methods to incorporate 'patient values and preferences' into clinical decision-making and evidence-based practice is the influential 'Grades of Recommendation, Assessment, Development and Evaluation (GRADE)' framework.[5] However, the guidelines this framework provides are somewhat vague, and they rely on information about what the 'typical' patient with a particular diagnosed condition prefers. As such, they are unlikely to consider a core concern of defenders of PCC, that each individual's specific life context is relevant to determining the best course of action in any particular case.[5,9] Other methods for basing practice on patient values and preferences have been described by authors including Mark Arnold and colleagues and Yves Aquino.[26,27] But as these authors astutely note, such methods have the often unintended consequence of reducing the dialogue about patient values to a process of 'demand and supply'—thus replacing the discussion of meaning and value crucial to any credible notion of shared decision-making with a consumerist model of healthcare.[9,26,27]

In the meantime, an increasing number of doctors realise that in the case of patients refusing treatment or not complying with medical advice, reasons may include 'a patient's personal philosophy'.[28] But caregivers or researchers who express the ideal of looking at the PPP rarely provide a rationale or method for how to do this systematically. To fill this gap, de Miranda developed and tested the SMILE_PH method in a pilot study conducted in 2022 that involved persons living with spinal cord injury (tetraplegia) and identifying themselves as having a good life.[22]

Research into philosophical health not only represents an opportunity to expand our understanding of what it means to treat patients 'as persons', but also to clarify critical components of the PCC lexicon, including the aforementioned terms 'patient expertise', 'patient empowerment', 'shared decision-making' and 'values-based practice'. Both PCC and the philosophical health approach are, in part, a reaction against the dominance of 'reductionist accounts of the person and the sort of narrow scientism that threatens to reduce both professional judgement and patient care to forms of technocracy'.[29] The problem here is not methodological reductionism in itself: authors in the field readily acknowledge that the received scientific approach is an appropriate methodology in many areas of scientific research, whose employment has unquestionably expanded our knowledge of biological processes.[9,16,18,21] The problem, instead, is that methodological reductionism all too easily slips into philosophical reductionism: from noting that the science of neurology has shown that specific brain processes are necessary if human emotions are even to be possible, some authors are inclined to conclude that a 'full' mapping of these chemical processes can tell us 'what emotions really are'[30,31]—as though the person's understanding of her own emotions could in principle be not only enhanced but actually replaced by the scientific account. Indeed, on this view, some are tempted to say it is the expert in neurology who knows what the emotional states of a given patient 'really are', not the patient actually experiencing those emotions and struggling to live with the problems they present.

Reductionism of this sort is not a scientific thesis but a theory *about* science[31]—one that regards the goal of science as being to reduce the world to its 'basic building blocks'[3] and to provide accounts that can 'explain away' the objects and processes of everyday life.[32] On such a view, people's accounts and understandings of their own lived experiences are, at best, 'low-grade evidence' and, at worse, irrelevant 'noise'. To exponents of the reductionist theory, it may seem like a natural or 'default' position to regard a person's own experiential knowledge as some manner of 'illusion'.[17,33] Thus, our notions of freedom, purpose and value become false beliefs to be explained away by science.[17–19,21]

As Stephen Tyreman notes, this reductionist mindset is highly pervasive. It generates the idea that society and culture should ultimately be reduced to psychology, which should, in turn, be reduced to biology, which should, in turn, be reduced to chemistry and physics.[3] In medical research and practice, he notes, this mindset involves a shift from understanding the mechanisms at work within an organism to treating the organism itself as a mechanism. It is this form of reductionism that gave rise to the still influential biostatistical theory of health, which effectively treats the body as a

bio-mechanism and treats health as the functioning of that mechanism within normal parameters—leading to the oft-quoted reactive definition of health as the absence of disease or dysfunction.[15]

With specific reference to 'disease', Alexandra Pârvan has argued that the split between disease/body and person is so enshrined in modern biomedical thinking that it has become an 'instinctive ontology', not only for biomedical theorists but also for practitioners and patients.[20] Health achievement is all too often equated with the identification and removal of a separate entity, the disease, that is treated as the cause of dysfunction, thus returning the body to its predisease status of normal functioning. A person-centred conception of health, Pârvan contends, must replace this instinctive ontology if we are to meet the challenges facing contemporary health services, including the rise of chronic conditions, co- and multimorbidity and the pressing need to facilitate 'health-within-illness'—and 'being healthy-with-disease'—for persons living with a wide range of diagnosed medical conditions.[20]

3 | PHILOSOPHY, HEALTH AND ENGAGEMENT

The question then arises as to how we reintroduce the more holistic understandings of organisms, persons and communities that defenders of PCC have argued are urgently needed to inform healthcare practice and to make us ready for the health challenges confronting us in future.[3,16–21] We believe the philosophical health approach can significantly contribute.

Far from being a purely abstract intellectual activity, unrelated to the processes of socially embodied life, philosophy is here understood as an interaction, or better, *intercreation* of sense—specifically, via dialogue, sense-making and sense-giving: it is awareness-raising and a form of therapy in the etymological sense of care.[11,13,21,23] Philosophy is care for the whole and the parts as they are part of the whole. The concern for the PPP can be understood as intellectual empathy, a thoughtful dialogue toward a more coherent set of beliefs, assumptions, principles, and philosophical values informing our actions. To care for the patient's personal philosophy means to care for the individual in the way he or she sees, understands, and approaches the world, life, and death.[34] PPP is an asymptotic process towards self-knowledge and knowledge of the world, and it deserves epistemic regard even if incomplete.

Practitioners or researchers have previously intuited the relationship between personal philosophy and health. For example, a study looked at what influences patient decision-making in amyotrophic lateral sclerosis care and found that 'a central influence on patient approaches to decision-making for symptom management and quality of life was the personal philosophy each held'.[35] Unfortunately, this study did not elaborate further on what these personal philosophies could be. What is certain is that people affected by illness still care about their quality of life. As Soren Ventegodt argued, the development of a beneficial personal philosophy of life and constructive life-affirming practice is the most crucial challenge for anyone who wants to be healthy: 'Improvement of quality of life in general seems to improve health, at least in the subjective dimensions, but it is not yet totally clear how to make such an improvement lasting. The most efficient strategy seems to be to improve the personal philosophy of life, to make the patient assume more responsibility for their own life by adjusting it to be in accordance with their purpose in life'.[36]

De Miranda characterises philosophical health as 'a state of fruitful coherence between a person's ways of thinking and speaking and their ways of acting, such that the possibilities for a sublime life are increased and the needs for self- and intersubjective flourishing satisfied'.[10] The notion of 'fruitful coherence' suggests a focus on the need for integration between the different aspects of our humanity if we are to realise our highest potential. The employment of the Aristotelian notion of 'flourishing', linked subsequently to the importance of a 'balance' between our physical, psychological and social aspects,[37] suggests that the realisation of this human potential is being equated with living a healthy life.

But what is health from a philosophical perspective? This is a much-disputed question. De Miranda equates health in general with a more or less strong sense of the possible (which as we will see below, is one of the elements of the SMILE_PH approach). This definition is clearly presented as a positive and value-laden alternative to the traditional, negative biomedical definition, presented by its defenders as value-neutral.[15] Other accounts of a person-centred approach to health and care also stress the need for an explicit focus on the concept of flourishing and the corresponding need to construe human beings as subjects of a whole life, embodied agents negotiating their physical and social environments, attempting to preserve or develop their identity, freedom and coherence in the context of an ever-changing world.[3,16,17] The idea of 'sublime life' rather than simply 'good life' proposed by de Miranda is part of a 'crealectic' theory that cannot be discussed here.[10,13,14] Still, the general idea is to introduce a nonnormative, aesthetically and radically subjective notion of what a good life is to avoid charges of replacing a scientistic dogmatism with a philosophical one. The sublime is a subjective experience, while the good can become an imposed standard.

All of this suggests that a philosophical health approach focusing on PPP represents a logical development of the strongest arguments for PCC in the current literature. There are, of course, less philosophically challenging or radical understandings of PCC. As Tyreman observes, PCC can be understood as 'a humanitarian addition to good medical practice—considering the person's personal needs and wishes on top of mending the body'.[3] Mitchell and Loughlin characterise this approach as 'normal science plus' the consideration of additional human, social and context-specific factors.[21] As noted above, such an approach seems implicit in the GRADE framework,[5] with its acknowledgement of the need to 'integrate' such 'subjective' factors as the personal 'values and preferences' of recipients of healthcare into a biomedical account of clinical reasoning. This approach presents person-centredness as a 'positive adjunct' to sound scientific practice, making the experience

of health services more bearable and potentially improving clinical outcomes. It poses no challenge to the dominant conceptions of science or the implicit ontology of biomedical determinism, presenting PCC as a merely desirable feature of clinical practice.[3] The price of this more 'moderate' or 'pragmatic' approach is, Tyreman notes, that it provides no 'theoretically compelling reasons' to make the person central to healthcare decisions when 'the medical focus is primarily on the workings of the body'.[3]

Critics have argued that an unintended consequence of this more 'pragmatic' form of PCC can be identified when we focus on its interpretation and implementation in policy contexts. Acknowledging and praising the progressive aspirations of its philosophical defenders, Arnold and colleagues note that the application of PCC terminology can be at odds with these aspirations—in particular, lending support to consumerist arrangements and an ideology of 'preference-driven healthcare'.[26] A simple conception of 'values-based practice,' characterised by its prominent defenders as a 'partner' to evidence-based medicine,[8,38] might well suggest that what the scientifically trained clinician brings to the decision-making process is knowledge of the facts, while the values are supplied by the patient/service-user. This would undoubtedly represent an overly simplistic reading of the influential 'two feet principle'—the view that clinical decision-making rests on the 'two feet' of 'scientific evidence' and 'values relevant to the individual patient situation'.[38] However, the critics note that in contemporary policy contexts, and without any explicit critique of the economically 'rationalised' system of healthcare which forms the context in which such decisions take place, this terminology can easily be used to provide a rationalisation for a consumerist approach to healthcare—one which can actually work against the consideration of social interests, the purpose of communities and processes needed to provide a more meaningful and less normative or financial notion of power than that provided by the consumerist paradigm.[26]

Aquino's work supplies the rather striking illustration of 'big-eye surgery'.[27] He cites evidence that growing numbers of Asian women are requesting surgical interventions to make the shape of their faces resemble more closely those of Caucasian women. Despite the frequent use of the term 'values and preferences' in the literature, an account of the distinction between the different sides of this conjunction is rarely offered,[5,9,21] perhaps suggesting the implicit equation of the values of the patient with that patient's expressed preferences at a given time.[19] If that is the case, the best way to 'respect the values' of the person requesting such surgery is simply to provide it. But if that is our understanding of 'person-centredness' and 'patient empowerment', then PCC merely replaces traditional medical paternalism with consumerism. Instead of the clinician determining what is best and the patient complying, the clinician provides the medical goods and services the alienated patient demands.

Neither one of these simplistic extremes incorporates any meaningful conception of 'shared decision-making' or intercreation of meaning. Hence the view of authors such as Tyreman that a more philosophically nuanced and challenging account of PCC is needed—one that treats PCC as a fundamental essential of practice, thus providing us with the theoretically compelling reason to be person-centred that is missing from the 'science plus' account.[3] Genuine engagement with and respect or empowerment of 'the whole person' involves learning more about that person's life, sense of purpose, philosophical sense and social context than simply asking her to confirm that 'big eye surgery' is indeed her preference, and proceeding to supply what this consumer demands. In the consumerist case, the patient's alienation and dependence on nonpersonal ideologies or worldviews remain unchallenged. Aesthetic judgements can reflect engrained stereotypes and prejudiced or oppressive attitudes. Actual patient existential growth, in this instance, might require challenging the racist, misogynistic or postcolonialist culture and campaigns driving the demand for this sort of intervention—the entrenched attitudes and social arrangements that make large numbers of people feel they are inherently inferior because they do not conform to an idealised appearance. In such a context, to agree to meet the patient's demand without deeper dialogue is to risk further entrenching the aesthetic prejudices that damage the health of entire groups of people. One does not respect or empower someone by simply asking them what they want among the available choices proposed by a given market society. One treats them equally by engaging with them in deep listening and philosophical sense-making. Our personal philosophy is not given at birth, but we can unveil it via thinking, philosophising, and dialogue, or more precisely, by using a method that allows us to do so.

It is imperative to develop an ongoing culture of inclusive critical reflection and philosophical conversation involving patients, practitioners and the broader public scene.[21] As de Miranda notes,[10] philosophy—the reflection on the fundamental assumptions and conceptions that frame our thoughts and acts—is not something engaged in only by a small group of academics: 'Any human being possesses philosophical beliefs, intellectual allegiances, and conceptual concerns, even if not yet fully explicit or compossible' and the role of philosophical dialogue is to try and render those underlying allegiances explicit and inter-compatible. To fail to engage in this sort of reflexive process is to 'allow one's ideas and attitudes, and ultimately one's behaviour, to be shaped by forces which one fails even to perceive, let alone control'.[23] We propose that philosophical health becomes a mainstream perspective, if not a new form of consciousness, at least as integral to our understanding of the health of the whole person as are physical and psychological health.

In what follows, we now outline an approach which attempts to implement this expanded conception of health.

4 | A SENSE-MAKING APPROACH

Illness threatens one's identity and purpose in life.[39] The idea that patients must change their personal philosophy and integrity to adapt to their ailment is still dominant in healthcare. In the last decades, one can often read in medical reports that one of the essential factors in achieving 'adequate medical management' is 'a change in the living

habits and personal philosophy of the patient'.[40] Asking patients to change their PPP without even being interested in its content is a form of epistemic violence.

Instead of telling patients to change their personal philosophies, the philosophical health approach proposes an intersubjective model. Using this model means entering into a sense-making dialogue, attempting to understand and unveil what deeply matters to the patient. Understanding the broader context of the patient's life and mind involves much more than simply inviting them to select between available interventions. It requires a thorough conversation, an 'interactional expertise' learning from the meaning we ascribe to our experiences.[25] Recognising and facilitating the patient's epistemic effort of self- and world-discovery may even require the realisation that, in addition to the clinical evidence available, this personal interaction with the patient may become an indispensable source of evidence in a treatment plan. Mary-Clair Yelovich proposes 'a new epistemological framework that recognises the legitimate knowledge offered by the patient as well as the physician'.[25] At least two aspects of the patient's tacit knowledge, argues Yelovich, are mainly accessible to the patient: the body and meaning aspects. To these bodily and philosophical senses, de Miranda's methodology adds the sense of self, the sense of belonging, the sense of the possible, and the sense of purpose.[13] All these senses create a field for 'negotiations of meaning'[25] and sense-making.

Persons are constituted by 'their unique set of experiences together with a narrative that interprets and gives meaning to them'.[3] It is only by understanding the nature and meaning of a specific person's unique narrative that we can assist them in giving direction to their human potential within the context of the complex and distinctive problems encountered on the specific journey that constitutes our shared experience of illness and social life. The concept of the person is relational. The dichotomy between understanding each person as unique and seeing each person as a community member—with an identity partly defined by belonging—is another conceptual divide that a philosophically informed conception of health may challenge. A proper account of the good of the individual requires understanding personhood as an ongoing interaction—intercreation—with the world, including communities, humans, nonhumans, bodies, the possible, the unknown and the natural environment.

It is often the case that before a philosophical health intervention, one's personal philosophy is mostly implicit or that, once made more explicit, it appears problematic and needs clarification or existential elaboration. Thus, intercreating the PPP via dialogue is essential, especially for patients facing serious decisions that can present themselves as irresolvable dilemmas—for instance, to undergo significant surgeries or screening and diagnostic tests for potentially stressful and severe pathologies.[41] The cause of the patient's uncertainty may concern the vagueness of their personal philosophy rather than the dilemma itself.

For patients, sense-giving and sense-making ensure that what they eventually decide conforms to the intuition of their personal philosophy. Co-unveiling the PPP through in-depth dialogue often allows for overcoming 'decisional paralysis'.[42] A patient can be in a decisional or existential paralysis not only because they fail to determine which means best conform to their ends, but also because one can be unsure about what the ends or purpose are. This may occur because patients seldom reflect systematically on their innermost values, beliefs and purpose or lack thereof, not having the guidance or training to do so. Our society is so dependent on money, divertissement and adjustment to the standard norms that little time is left to philosophise. If we agree that it is unhealthy not to be able to think deeply about what matters, then philosophical health should be provided as a healthcare service.

The method designed by de Miranda proposes that we should engage in sense-making to unveil the PPP. As said, in 2022, de Miranda designed and tested, under the approval of the Swedish Ethical Review Authority, a semi-structured phenomenological method called SMILE_PH.[22] For the purpose of disseminating the philosophical-health methodology, philosophically oriented first-person interviews should be made possible in a manner that can be reproduced, compared and used systematically. SMILE_PH, an acronym for *Sense-Making Interviews Looking at Elements of Philosophical Health*, was conceived during a study focused on the philosophy of life of persons living a flourishing life despite a tetraplegic condition following a spinal cord injury (SCI) which left them almost entirely paralysed physically.

A core notion in first-person approaches,[43] sense-making is at the core of the SMILE_PH approach. We constantly make decisions grounded in how the world appears to us as embodied beings.[44] Such appearances are never neutral but always perspectival. Our first-person experience of the world is interpretative in a more or less blurry and messy way.[45] *Sense* refers to an embodied perception that attempts to evaluate its environment and transpose it into meaningful action, intuition or thinking. Persons are a continuous and transformative process of evaluations and points of view on specific situations or problems to which they seek to enact meaningful responses.[46] The implicit or explicit intention of sense-making may be to construct order over apparent chaos.[47] Such a process mobilises intertwined corporeal, emotional and cognitive dimensions.[48] Sense-making is thus a term commonly understood as the process through which people interpret and give meaning to their experiences.[49] This process is progressive and may start with somewhat confused impressions. As Chia puts it, we may start with 'an undifferentiated flux of fleeting sense-impressions', and it is out of this 'flux of lived experience' that attention proposes frames and conceptions: meanings 'have to be forcibly carved out of the undifferentiated flux of raw experience and conceptually fixed and labelled so that they can become the common currency for communicational exchanges'.[50]

The SMILE_PH method co-creates a phenomenological narrative with the patient in the following order.

4.1 | Question 1—The bodily sense

The SMILE-PH conversation begins by addressing an individual's bodily sense, which encompasses the ways in which they feel and

perceive their body. This exploration touches on various scientific and philosophical concepts, such as embodiment. Embodiment, a concept found in both cognitive science and philosophy, refers to the idea that our cognitive processes are deeply rooted in our physical body and how we interact with our environment. Philosophers like Merleau-Ponty[51] and Lakoff and Johnson[52] among others, argue that our body is not a mere vessel for our mind but rather an integral part of our thoughts, emotions and experiences. Phenomenology places a strong emphasis on the importance of subjective experience and considers bodily sensations as an essential aspect of our perception of the world.[53,54] Drawing from phenomenology, one can explore the intricate relationship between bodily sensations, emotions and our overall sense of self. Expanding on these concepts, variants of the initial SMILE-PH question might delve deeper into specific aspects of an individual's bodily sense. For example:

How do you experience the relationship between your bodily sensations and your emotions?

Can you describe a situation where your body and emotions were closely connected?

In what ways do you think your bodily experiences have shaped your understanding of life?

Do you believe your body and mind are separate entities, or do you view them as interconnected? Why do you feel that way?

4.2 | Question 2—The sense of self

The second element in a SMILE-PH interview focuses on an individual's sense of self, which explores how they perceive and feel about themselves. This examination involves various concepts such as self-concept, self-awareness, and personal identity. Self-concept refers to an individual's mental representation of themselves, encompassing their beliefs, attitudes, and evaluations regarding their own abilities, traits, and characteristics. Carl Rogers argues that self-concept plays a crucial role in human behaviour and mental health, as it influences how individuals perceive and interact with their environment.[55] Self-awareness involves the conscious knowledge of one's own character, feelings, motives and desires. Neuroscientist Antonio Damasio suggests that self-awareness arises from the continuous integration of bodily sensations, emotions, and cognitive processes, leading to the emergence of a sense of self.[56] Personal identity pertains to the question of what makes a person distinct from others and what constitutes their continuity over time. Philosophers such as John Locke and Derek Parfit have provided different accounts of personal identity, emphasizing either psychological continuity or the importance of various relations and connections. According to Locke, personal identity is based on the continuity of consciousness, which includes memories, thoughts and experiences.[57] Parfit maintained that personal identity is a complex web of interrelated experiences and characteristics rather than a single, unified self.[58] Expanding on these concepts, variants of the SMILE-PH question about the sense of self might delve deeper into specific aspects of an individual's self-perception.

It is vital within each question of the SMILE_PH approach to let the patient elaborate, and the interviewer is advised to ask contextual subquestions that demonstrate deep listening. However, depending on what the patient says, the following subquestions may be asked:

Can you provide an example of a situation where you felt proud of yourself?

How does your history or current context contribute to your sense of self?

In what ways do your relationships with others influence your sense of self?

How do you feel your sense of self is impacted by your social environment?

Do you believe your self is a constant entity or something that evolves over time? Why do you feel that way?

4.3 | Question 3—The sense of belonging

The third step in the SMILE-PH approach revolves around an individual's sense of belonging, which can be perceived as depleted, problematic, fulfilled, or free-flowing. This exploration involves various scientific and philosophical concepts such as social identity theory, attachment theory or existentialism.

Social identity theory posits that an individual's sense of self is shaped by their identification with social groups. According to Henri Tajfel and John Turner, among others, people derive a sense of belonging and self-esteem from their group memberships, which can significantly influence their attitudes, emotions and behaviour.[59] Attachment theory emphasizes the importance of secure and supportive relationships for individuals' emotional well-being and development. Bowlby[60] argues that a sense of belonging is closely tied to the quality of our early attachments, which can impact our capacity for forming meaningful connections throughout our lives. Existentialism, usually associated with Sartre and Camus, insists on individual freedom, personal responsibility, and the need to create meaning in life. From an existentialist perspective, a sense of belonging can be understood as the result of individuals actively engaging with their world and forging connections with others based on shared values and experiences.[61] De Miranda's *Ensemblance*[62] provides an exhaustive intellectual history of the concept of esprit de corps—group attachment as defined initially and critically by the French philosophers of the Enlightenment—and how it was variously associated in the last three centuries with well-belonging or ill-belonging, solidarity or groupthink.

Variants of the SMILE-PH question about the sense of belonging might delve deeper into specific aspects of a person's connections to others and the world. For example:

How have your experiences with different social groups shaped your sense of belonging?

Can you provide an example of a group that has had a significant impact on your life?

In what ways do your closest relationships contribute to your sense of belonging?

How have these relationships evolved over time?

Do you believe your sense of belonging is primarily determined by external factors, such as social groups and relationships, or by your personal choices and actions? Why do you feel that way?

4.4 | Question 4—The sense of the possible

Step 4 of the SMILE-PH interview delves into an individual's sense of the possible, which explores their perception of potential opportunities and personal agency. This investigation involves various scientific and philosophical concepts, such as self-efficacy, optimism and again existentialism.

Self-efficacy, a concept introduced by Bandura, refers to an individual's belief in their ability to accomplish specific tasks or achieve certain goals. According to Bandura, self-efficacy plays a crucial role in determining our motivation, persistence and success in various domains of life.[63] A strong sense of self-efficacy can enhance an individual's perception of the possible, increasing their confidence in their capacity to seize opportunities and overcome challenges. Optimism pertains to an individual's general tendency to expect—or demand—positive outcomes in life. Optimistic individuals tend to have a more expansive sense of the possible. They are likelier to perceive opportunities and focus on potential gains rather than losses, even after a bad experience. Research by Seligman has shown that optimism is linked to various aspects of well-being, including physical health, emotional resilience, and life satisfaction.[64] From an existentialist perspective, the sense of the possible can be understood as a reflection of an individual's active engagement with the world, their capacity to make choices, and their willingness to take responsibility for their actions rather than be limited by *bad faith*—justifications about how the personal past or former negative experiences are possibility-limiting.[61] Here phenomenology was influential, in particular, Heidegger and his follower Binswanger, who insisted on the ontological importance of *possibilizing* as part of the universe's becoming and therefore, on re-possibilization as healing.[65]

Expanding on these concepts, variants of the SMILE-PH question about the sense of the possible—which de Miranda calls *eudynamia* when well-balanced—[13] might delve deeper into specific aspects of an individual's perception of opportunities and personal agency. For example (and again, these questions should not be seen as normative but rather as suggestions which should be rephrased depending on the context provided by the interviewee):

How does your confidence in your own abilities influence your perception of the possible?

Can you provide an example of a situation where your self-optimism shaped your approach to opportunities or challenges?

How do your attitudes toward the future impact your sense of the possible? How have these attitudes evolved over time?

Do you believe your sense of the possible is primarily determined by external factors, such as societal norms and expectations, or by your personal choices and actions? Why do you feel that way?

4.5 | Question 5—The sense of purpose

The fifth element of the SMILE-PH method concerns an individual's sense of purpose, which explores their perception of higher personal goals, value admirations and aspirations.

Meaning in life refers to how individuals perceive their lives as significant, purposeful, and coherent. According to Steger, a strong sense of purpose is a central component of meaning in life. It gives individuals clear goals, direction and motivation to engage in personally meaningful activities.[66] *Eudaimonia*, a concept rooted in ancient Greek philosophy, pertains to the idea of living a life of virtue and striving for self-realization. Aristotle posited that the ultimate goal of human life is to achieve eudaimonia, which entails cultivating one's character, fulfilling one's potential for excellence and contributing to the well-being of others. A sense of purpose is closely related to eudaimonia, as it guides individuals in pursuing personal growth and flourishing.[67] One could argue with Aristotle and Plato that purpose is akin to authentic politics: evaluating the conditions for achieving paradise on Earth for all and beginning to act now to transform our practices accordingly.[13]

Expanding on these ideas, variants of the SMILE-PH question about the sense of purpose might delve deeper into specific aspects of an individual's long-term goals, values and aspirations. For example:

How do your personal values and beliefs shape your sense of purpose, if you have one?

Can you describe a situation where your values guided your actions and decisions?

In what ways do your relationships with others and your contributions to their well-being influence your sense of purpose? How have these connections evolved over time?

Do you believe your sense of purpose is primarily determined by external factors, such as cultural or societal expectations, or by your personal choices and values? Why do you feel that way?

4.6 | Question 6—The philosophical sense

The final step of the SMILE-PH dialogue focuses on a person's philosophical sense, exploring their worldviews, perspectives on life, and the healing and liberating aspects of personal philosophy.

The SMILE_PH method was inspired by de Miranda's philosophical own counselling practice, which started in 2018.[13] Philosophical counselling, a practice that applies philosophical concepts and methods to help individuals navigate personal challenges and psychological distress, highlights the healing and liberating potential of philosophy. Pioneered by thinkers like Achenbach and Marinoff, philosophical counselling encourages self-reflection, critical thinking, and open dialogue to foster personal growth and resolve existential concerns.[68] The therapeutic aspects of philosophy refer to the ways in which engaging with philosophical ideas can promote emotional healing, self-awareness, and personal transformation. For instance, the Stoic teachings of Epictetus and Marcus Aurelius emphasize the

importance of cultivating inner resilience, practising *full-mindedness* (a term de Miranda proposed to replace *mindfulness*), and developing a balanced perspective to overcome life's challenges.[69]

Having a philosophical sense also means having shaped or being in the process of shaping one's worldview, also known as a world perspective or Weltanschauung.[70] It is a comprehensive framework of ideas, beliefs, and values through which an individual understands, interprets, and interacts with the world around them. Worldviews encompass various aspects of human experience, including religion, ethics, science, culture, and personal identity, and can significantly influence a person's or a group's thoughts, actions, and decisions.[71] The final step of the SMILE-PH dialogue addresses the person's worldview as an essential part of their philosophical sense. By unveiling and intercreating the foundations of one's worldview and its past or possible impact on one's existence, the SMILE-PH conversation can help promote self-awareness, personal growth and philosophical health. Engaging critically with different worldviews can be healing and liberating, allowing individuals to broaden their perspectives, challenge their assumptions, and foster empathy and understanding toward others.[72]

Expanding on these concepts, variants of the SMILE-PH question about the philosophical sense might delve deeper into specific aspects of an individual's worldviews and the healing and liberating aspects of their personal philosophy. For example:

How do your personal views and values shape your philosophy of life?

Can you describe a situation where your philosophical beliefs guided your actions or decisions?

How could engaging with philosophical ideas or adopting a specific worldview help you navigate difficult situations or personal challenges? Can you provide an example?

How does your personal philosophy contribute to your overall well-being?

How would you connect your sense of purpose with a worldview?

How has your philosophical sense influenced your relationships with others and your contributions to their well-being?

Can you share an example of a time when your worldview or the lack thereof generated a change in yourself or others?

5 | CONCLUSION

A high sense of the possible or *eudynamia*[13] is what deep health is about. This personal construct is not only a feeling or an intuition, but also the result of intellectual and existential self-reflection. Sense-making, and a sense-making dialogue, is about the continued redrafting of an emerging narrative to allow the patient to co-create their worldview and understand their lifeworld in a more comprehensive and explicit manner[73] and lead to the construction of the kind of robust identity or integrity[74] needed to face the adversity of illness. This process of shaping unity out of an embodied source of experiences necessitates at least internal dialogue, and, for nonphilosophers, a dialogue with a philosophical counsellor or a trained interviewer. In the case of patients and caregivers who are not philosophers by training, the SMILE_PH method is, we believe, a viable method for systematically implementing person-centred care via intercreative work on the PPP. We suggest now conducting further evaluations of real-life studies or interventions to validate the claim that philosophical health, in general, and the SMILE_PH method, in particular, are good candidates for large-scale PPP implementations or interventions.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no data sets were generated or analysed during the current study.

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